		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043901

Facility Name: The Claremont of Lee County

Address: 800 Division Street (Number) Dixon (City) 61021 (Zip Code)

County: Lee

Telephone Number: (815) 284-3393 **Fax #** (815) 284-2066

IDPA ID Number: 364217150001

Date of Initial License for Current Owners: 06/01/1998

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[x]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[x]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	97	Skilled (SNF)	97	35,405	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,405	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,113	1,078	1,186	8,377	8
9	SNF/PED					9
10	ICF	8,742	11,693		20,435	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/01/1998

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 06/01/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 13 and days of care provided 1,167

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

14	TOTALS	14,855	12,771	1,186	28,812	14	

Is your fiscal year identical to your tax year? YES [X] NO [ ]

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.38%

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	156,965	25,645	7,083	189,693		189,693		189,693			1
2	Food Purchase		129,507		129,507		129,507	(1,908)	127,599			2
3	Housekeeping	105,808	11,619		117,427		117,427	(880)	116,547			3
4	Laundry	40,330	11,210		51,540		51,540		51,540			4
5	Heat and Other Utilities			84,287	84,287		84,287		84,287			5
6	Maintenance	27,691	14,530	31,204	73,425		73,425		73,425			6
7	Other (specify):*											7
8	**TOTAL General Services**	330,794	192,511	122,574	645,879		645,879	(2,788)	643,091			8
	B. Health Care and Programs											
9	Medical Director			1,750	1,750		1,750		1,750			9
10	Nursing and Medical Records	1,050,566	81,886	135,411	1,267,863		1,267,863		1,267,863			10
10a	Therapy	54,689	8,874		63,563		63,563		63,563			10a
11	Activities	82,448		7,175	89,623		89,623		89,623			11
12	Social Services	13,440		1,766	15,206		15,206		15,206			12
13	Nurse Aide Training	29,520	1,950		31,470		31,470		31,470			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,230,663	92,710	146,102	1,469,475		1,469,475		1,469,475			16
	C. General Administration											
17	Administrative	55,726			55,726		55,726		55,726			17
18	Directors Fees											18
19	Professional Services			79,842	79,842		79,842	(10,808)	69,034			19
20	Dues, Fees, Subscriptions & Promotions			11,902	11,902		11,902	(24)	11,878			20
21	Clerical & General Office Expenses	129,245	13,686	22,143	165,074		165,074		165,074			21
22	Employee Benefits & Payroll Taxes			340,396	340,396		340,396		340,396			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,893	3,893		3,893		3,893			24
25	Other Admin. Staff Transportation			3,288	3,288		3,288		3,288			25
26	Insurance-Prop.Liab.Malpractice			71,743	71,743		71,743		71,743			26
27	Other (specify):*											27
28	**TOTAL General Administration**	184,971	13,686	533,207	731,864		731,864	(10,832)	721,032			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,746,428	298,907	801,883	2,847,218		2,847,218	(13,620)	2,833,598			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** **SEE ACCOUNTANTS' COMPILATION REPORT**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Claremont of Lee County #0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			3,005	3,005		3,005	33,805	36,810			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,789	33,789		33,789	75,491	109,280			32
33	Real Estate Taxes			9,366	9,366		9,366	30,938	40,304			33
34	Rent-Facility & Grounds			178,129	178,129		178,129	(106,429)	71,700			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			224,289	224,289		224,289	33,805	258,094			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		21,572	279	21,851		21,851	(1,704)	20,147			39
40	Barber and Beauty Shops			6	6		6		6			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,107	53,107		53,107		53,107			42
43	Other (specify):* Nonallowable costs	28,267	5,476	20,948	54,691		54,691	(25,116)	29,575			43
44	**TOTAL Special Cost Centers**	28,267	27,048	74,340	129,655		129,655	(26,820)	102,835			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,774,695	325,955	1,100,512	3,201,162		3,201,162	(6,635)	3,194,527			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,908)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,384)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,591	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(547)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,808)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(15,017)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,024)	20		28
29	Other-Attach Schedule See Schedule 5A	(6,752)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,849)		$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	33,214		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 33,214		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (6,635)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

OHF USE ONLY									
48		49		50		51		52	

SEE ACCOUNTANTS' COMPILATION REPORT

The Claremont of Lee County

ID# 0043901

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23

24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Claremont of Lee County # 0043901 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,908)	0	0	0	0	0	0	0	0	0	0	(1,908)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,908)	0	0	0	0	0	0	0	0	0	0	(1,908)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,808)	0	0	0	0	0	0	0	0	0	0	(10,808)	19
20	Fees, Subscriptions & Promotions	(1,024)	1,000	0	0	0	0	0	0	0	0	0	(24)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(11,832)	1,000	0	0	0	0	0	0	0	0	0	(10,832)	28

29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	**(13,740)**	**1,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(12,740)**	**29**

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number The Claremont of Lee County **#** 0043901 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,591	32,214	0	0	0	0	0	0	0	0	0	33,805	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	75,491	0	0	0	0	0	0	0	0	0	75,491	32
33	Real Estate Taxes	0	30,938	0	0	0	0	0	0	0	0	0	30,938	33
34	Rent-Facility & Grounds	0	(106,429)	0	0	0	0	0	0	0	0	0	(106,429)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,591	32,214	0	0	0	0	0	0	0	0	0	33,805	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(20,948)	0	0	0	0	0	0	0	0	0	0	(20,948)	43
44	**TOTAL Special Cost Centers**	(20,948)	0	0	0	0	0	0	0	0	0	0	(20,948)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(33,097)	33,214	0	0	0	0	0	0	0	0	0	117	45

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bruce Lederman	95.08%	Windsor Manor Nursing & Rehabiliation Ctr	Palos Hills, IL	Dixon Property LLC	Dixon, IL	Real Estate
Andrea Weitzburg	4.92%	Claremont of Buffalo Grove	Buffalo Grove, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	30	Depreciation		Dixon Property LLC	100.00%	32,214	32,214	2
3	V	32	Interest		Dixon Property LLC	100.00%	75,491	75,491	3
4	V	33	Real Estate Taxes		Dixon Property LLC	100.00%	30,938	30,938	4
5	V	34	Rent	106,429	Dixon Property LLC	100.00%		(106,429)	5
6	V	20	Dues, Fees, Subscriptions		Dixon Property LLC	100.00%	1,000	1,000	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 106,429			$ 139,643	$ * 33,214	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5		N/A								5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Park National Bank & Trust		x	Mortgage	N/A	03/28/01	$ 1,350,000	$ 1,350,000	06/28/02	P+.0050	$ 75,491	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LaSalle National Bank		x	Working Capital	$5,357.00	8/2/2001	450,000	428,571	7/1/2002	P +.0025	33,789	6
7												7
8												8
9	TOTAL Facility Related				$5,357.00		$ 1,800,000	$ 1,778,571			$ 109,280	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,800,000	$ 1,778,571			$ 109,280	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 40,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 39,254	2
3. Under or (over) accrual (line 2 minus line 1).		$ (946)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 41,250	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 40,304	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998	19,237	10
1999	38,287	11
2000	39,254	12

2000 taxes paid	39,254
Est increase	1.05%
	41,217 - use 41,250

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Claremont of Lee County COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0043901

CONTACT PERSON REGARDING THIS REPORT Vicky DeBord

TELEPHONE (815) 284-3393 FAX #: (815) 284-2066

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-08-04-376-999	00000800 Division St	$ 39,254.00	$ 39,254.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,254.00	$ 39,254.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,700 B. General Construction Type: Exterior Block / Brick Frame Metal / Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. 3/29 - 12/31/01 [x] (c) Rent from Completely Unrelated Organization. 1/1 - 3/28/01

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	Not Available	2001	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	97		2001	1973	$ 1,318,091	$ 24,714	40	$ 24,714	$	$ 24,714	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof repair			1998	20,160	272	25	806	534	3,224	9
10	Aviary			1998	4,486	183	25	179	(4)	627	10
11	New Windows			1997	581		10	58	58	208	11
12	Repair furnace, A/C			1997	2,026		10	203	203	727	12
13	Repair refrigerator, replace A/C			1998	5,334		10	533	533	1,910	13
14	Network wiring installation, door monitoring system			1998	2,269		10	227	227	813	14
15	Kitchen fire system			1999	898		24	37	37	93	15
16	Wall			1999	955	38	24	40	2	100	16
17	Heating & air conditioning			1999	4,146	173	24	173	(0)	432	17
18	Heating & air conditioning			1999	2,988	124	24	125	1	311	18
19	Fence			2000	1,843	80	23	80	0	120	19
20	Thermostat			2000	1,779	78	23	78		117	20
21	Fence			2001	1,290	43	15	43		43	21
22	Sign			2001	740	25	15	25		25	22
23	Outside painting			2001	5,628	188	15	188		188	23
24	Light Fixtures			2001	1,753	58	15	58		58	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,374,967	$ 25,976		$ 27,567	$ 1,591	$ 33,710	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,374,967	$ 25,976		$ 27,567	$ 1,591	$ 33,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,374,967	$ 25,976		$ 27,567	$ 1,591	$ 33,710	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,374,967	$ 25,976		$ 27,567	$ 1,591	$ 33,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,374,967	$ 25,976		$ 27,567	$ 1,591	$ 33,710	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,374,967	$ 25,976		$ 27,567	$ 1,591	$ 33,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,374,967	$ 25,976		$ 27,567	$ 1,591	$ 33,710	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 16,418	$ 1,642	$ 1,642	$	10	$ 3,353	71
72	Current Year Purchases	102,024	7,601	7,601		10	7,601	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 118,442	$ 9,243	$ 9,243	$		$ 10,954	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,593,409	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,219	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 36,810	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,591	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 44,664	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Building addition	$ 70,143	92
93			93
94			94
95		$ 70,143	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** **This must agree with Schedule V line 30, column 8.**

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: County of Lee, Illinois - thru 03/28/01

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [x] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1973	97	06/01/98	$ 71,700	3	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		97		$ 71,700 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [x] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning 06/01/1998
Ending 03/28/01

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[x]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[ ]
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[x]
IN OTHER FACILITY	[ ]
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		1,950		1,950
3	Classroom Wages (a)		13,920		13,920
4	Clinical Wages (b)		6,960		6,960
5	In-House Trainer Wages (c)		8,640		8,640
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 31,470	$	$ 31,470
10	SUM OF line 9, col. 1 and 2 (e)	$ 31,470			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 450

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	29
2. From other facilities (f)	4
DROP-OUTS	
1. From this facility	7
2. From other facilities (f)	
TOTAL TRAINED	40

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C1,2	1120	hrs	$ 24,093		$	$ 2,640	1,120	$ 26,733	1
2	Licensed Speech and Language Development Therapist	L10a, C2		hrs				2,882		2,882	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L10a, C1,2	1422	hrs	30,596			3,352	1,422	33,948	4
5	Physician Care	L39, C3		visits		6	279			279	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	L39, C2		# of prescrpts				19,868		19,868	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):							1,704		1,704	13
14	TOTAL				$ 54,689	6	$ 279	$ 30,446	2,542	$ 85,414	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 62,147	$ 62,147	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	918,286	918,286	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,345	17,345	6
7	Other Prepaid Expenses	19,547	19,547	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,017,325	$ 1,017,325	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		100,000	13
14	Buildings, at Historical Cost		1,318,091	14
15	Leasehold Improvements, at Historical Cost	32,223	56,876	15
16	Equipment, at Historical Cost	18,442	118,442	16
17	Accumulated Depreciation (book methods)	(6,430)	(44,664)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Deposit**	115,361		22
23	Other(specify): See Schedule 17A	64,433	78,008	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 224,029	$ 1,626,753	24

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 339,251	$ 339,251	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	428,571	428,571	29
30	Accrued Salaries Payable	84,013	84,013	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,312	41,250	32
33	Accrued Interest Payable	1,878	5,378	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	9,849	9,849	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 873,874	$ 908,312	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,350,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		845,774	874,152	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 845,774	$ 2,224,152	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,719,648	$ 3,132,464	46

25	TOTAL ASSETS (sum of lines 10 and 24)	$ 1,241,354	$ 2,644,078	25

47	TOTAL EQUITY(page 18, line 24)	$ (478,294)	$ (488,386)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ 1,241,354	$ 2,644,078	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (463,354)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (463,354)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(14,940)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (14,940)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (478,294)	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,014,768	1
2	Discounts and Allowances for all Levels	(31,814)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,982,954	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	84,162	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 84,162	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	450	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	3,456	15
16	Rental of Facility Space		16
17	Sale of Drugs	31,746	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,837	19
20	Radiology and X-Ray	1,350	20
21	Other Medical Services	59,054	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 110,893	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	645,879	31
32	Health Care	1,469,475	32
33	General Administration	731,864	33
	B. Capital Expense		
34	Ownership	224,289	34
	C. Ancillary Expense		
35	Special Cost Centers	76,548	35
36	Provider Participation Fee	53,107	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,201,162	40
41	**Income before Income Taxes (line 30 minus line 40)****	(14,940)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (14,940)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	8,213	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 8,213	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 3,186,222	30

Client is a cash basis taxpayer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 44,508	$ 21.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,490	6,957	104,907	15.08	3
4	Licensed Practical Nurses	23,654	24,491	288,998	11.80	4
5	Nurse Aides & Orderlies	57,371	58,160	489,727	8.42	5
6	Nurse Aide Trainees	3,960	3,960	29,520	7.45	6
7	Licensed Therapist	2,382	2,542	54,689	21.51	7
8	Rehab/Therapy Aides	5,207	5,884	71,842	12.21	8
9	Activity Director	2,052	2,220	20,543	9.25	9
10	Activity Assistants	6,719	6,975	61,905	8.88	10
11	Social Service Workers	1,730	1,810	13,440	7.43	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	22,885	11.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,846	20,752	134,080	6.46	15
16	Dishwashers					16
17	Maintenance Workers	2,942	3,086	27,691	8.97	17
18	Housekeepers	12,670	13,298	105,808	7.96	18
19	Laundry	3,729	3,927	40,330	10.27	19
20	Administrator	1,960	2,080	55,726	26.79	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,180	13,571	129,245	9.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,424	1,476	10,730	7.27	31
32	Other Health C: Sch 20A	2,699	2,799	39,854	14.24	32
33	Other(specify) Daycare	2,554	2,554	28,267	11.07	33

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	164	$ 7,083	L1, C3	35
36	Medical Director	Monthly	1,750	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	17	1,698	L11, C3	44
45	Social Service Consultant	29	1,766	L12, C3	45
46	Other(specify) Alzheimers Program	98	2,156	L11, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	308	$ 16,253		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	2,052	61,573		51
52	Nurse Aides	3,894	72,038		52
53	TOTAL (lines 50 - 52)	5,946	$ 133,611		53

34	TOTAL (lines 1 - 33)	174,529	180,702	$ 1,774,695 *	$ 9.82	34	SEE ACCOUNTANTS' COMPILATION REPORT

*** This total must agree with page 4, column 1, line 45.** **** See instructions.**

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Vicky DeBord	Administrator	0%	$ 55,726
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,726

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Laner Muchin Dumbrow	Legal	$ 10,808
Altschuler Melvoin&Glasser LLP	Accounting	17,744
American Express TBS	Accounting	26,234
Personnel Planners	UC Consulting	1,421
Fish & Jacobson	Legal	165
Systematic Mgmt Systems	Billing Service	6,389
MDI	Computer Processing	3,900
ADP	Payroll	11,902
William & Mary Computer Svce	Computer Service	779
Barbara Geltner	CNA Evaluator	500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 79,842

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,278
Unemployment Compensation Insurance	13,187
FICA Taxes	134,542
Employee Health Insurance	129,666
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee physicals	660
Other employee benefits	2,063
TOTAL (agree to Schedule V, line 22, col.8)	$ 340,396

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	8,428
Health Care Worker Background Check	
(Indicate # of checks performed 154)	1,850
Annual report	200
Illinois Dept of Public Health	1,000
Advertising - yellow pages	1,024
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(1,024)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,878

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	788
Seminar Expense	3,105
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,893

*** Attach copy of IMRF notifications** ****See instructions.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Claremont of Lee County # 0043901 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 6,082 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 53,107
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? Yes Indicate the amount. $ 1,908

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	156,965	25,645	7,083	189,693	0	189,693	0	189,693
2. Food Pı	0	129,507	0	129,507	0	129,507	-1,908	127,599
3. Housek	105,808	11,619	0	117,427	0	117,427	0	117,427
4. Laundry	40,330	11,210	0	51,540	0	51,540	-880	50,660
5. Heat an	0	0	84,287	84,287	0	84,287	0	84,287
6. Mainter	27,691	14,530	31,204	73,425	0	73,425	0	73,425
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	330,794	192,511	122,574	645,879	0	645,879	-2,788	643,091
9. Medical	0	0	1,750	1,750	0	1,750	0	1,750
10. Nursin	1,050,566	81,886	135,411	1,267,863	0	1,267,863	0	1,267,863
10a. Thera	54,689	8,874	0	63,563	0	63,563	0	63,563
11. Activiti	82,448	0	7,175	89,623	0	89,623	0	89,623
12. Social	13,440	0	1,766	15,206	0	15,206	0	15,206
13. Nurse	29,520	1,950	0	31,470	0	31,470	0	31,470
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	1,230,663	92,710	146,102	1,469,475	0	1,469,475	0	1,469,475
17. Admin	55,726	0	0	55,726	0	55,726	0	55,726
18. Directo	0	0	0	0	0	0	0	0
19. Profes	0	0	79,842	79,842	0	79,842	-10,808	69,034
20. Fees,	0	0	11,902	11,902	0	11,902	-24	11,878
21. Clerica	129,245	13,686	22,143	165,074	0	165,074	0	165,074
22. Emplo	0	0	340,396	340,396	0	340,396	0	340,396
23. Inservi	0	0	0	0	0	0	0	0
24. Travel	0	0	3,893	3,893	0	3,893	0	3,893
25. Other	0	0	3,288	3,288	0	3,288	0	3,288

26.	Insura	0	0	71,743	71,743	0	71,743	0	71,743
27.	Other	0	0	0	0	0	0	0	0
28.	Total (	184,971	13,686	533,207	731,864	0	731,864	-10,832	721,032
29.	Total (	1,746,428	298,907	801,883	2,847,218	0	2,847,218	-13,620	2,833,598
30.	Depre	0	0	3,005	3,005	0	3,005	33,805	36,810
31.	Amorti	0	0	0	0	0	0	0	0
32.	Interes	0	0	33,789	33,789	0	33,789	75,491	109,280
33.	Real E	0	0	9,366	9,366	0	9,366	30,938	40,304
34.	Rent -	0	0	178,129	178,129	0	178,129	-106,429	71,700
35.	Rent -	0	0	0	0	0	0	0	0
36.	Other	0	0	0	0	0	0	0	0
37.	Total (	0	0	224,289	224,289	0	224,289	33,805	258,094
38.	Medic	0	0	0	0	0	0	0	0
39.	Ancilla	0	21,572	279	21,851	0	21,851	-1,704	20,147
40.	Barbe	0	0	6	6	0	6	0	6
41.	Coffee	0	0	0	0	0	0	0	0
	42	0	0	53,107	53,107	0	53,107	0	53,107
43.	Other	28,267	5,476	20,948	54,691	0	54,691	-25,116	29,575
44.	Total S	28,267	27,048	74,340	129,655	0	129,655	-26,820	102,835
45.	Grand	1,774,695	325,955	1,100,512	3,201,162	0	3,201,162	-6,635	3,194,527

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	62,147	62,147
2. Cash - F	0	0
3. Account	918,286	918,286
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	17,345	17,345
7. Other Pr	19,547	19,547
8. Account	0	0
9. Other (s	0	0
10. Total c	1,017,325	1,017,325
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	100,000
14. Buildin	0	1,318,091
15. Leaseh	32,223	56,876
16. Equipm	18,442	118,442
17. Accum	-6,430	-44,664
18. Deferre	0	0
19. Organi:	0	0
20. Accum	0	0
21. Restric	0	0
22. Other L	115,361	0
23. other (s	64,433	78,008
24. Total L	224,029	1,626,753
25. Total A	1,241,354	2,644,078
CURRENT LIABILITIES		
26. Accour	339,251	339,251

27. Officer'	0	0
28. Accour	0	0
29. Short-T	428,571	428,571
30. Accrue	84,013	84,013
31. Accrue	0	0
32. Accrue	10,312	41,250
33. Accrue	1,878	5,378
34. Deferre	0	0
35. Federa	0	0
36. Other C	9,849	9,849
37. Other C	0	0
38. Total C	873,874	908,312
LONG TERM LIABILITES		
39.Long-Te	0	0
40.Mortgag	0	1,350,000
41.Bonds F	0	0
42.Deferre	0	0
43.Other L	845,774	874,152
44.Other L	0	0
45.Total Lo	845,774	2,224,152
46.Total Li	1,719,648	3,132,464
47.Total Ec	-478,294	-488,386
48.Total Li	1,241,354	2,644,078

		Balance per Medicaid Trial Balance
1.	Gross F	3,014,768
2.	Discour	-31,814
	Subtota	2,982,954
4.	Day Ca	0
5.	Other C	0
6.	Therapy	84,162
7.	Oxygen	0
	Subtota	84,162
9.	Paymer	0
10.	Other	0
11.	Nurses	450
12.	Gift an	0
13.	Barber	0
14.	Non-P	0
15.	Telepł	3,456
16.	Rental	0
17.	Sale o	31,746
18.	Sale o	0
19.	Laborá	14,837
20.	Radiol	1,350
21.	Other	59,054
22.	Laund	0
	Subtot	110,893
24.	Contril	0
25.	Interes	0

	Subtot	-
27.	Other	8,213
28.	Other	0
	Subtot	8,213
30.	Total F	3,186,222
31.	Gener	680,120
32.	Health	1,154,988
33.	Gener	668,561
34.	Owner	144,710
35.	Specia	60,174
35.	Provid	41,063
37.	Other	0
40.	Total E	2,749,616
41.	Incom	436,606
42.	Incom	0
43.	Net In	436,606

Page

Attachment of Real Estate Bill and fill out form

P12 does not show totals, it carries to P12a, therefore P12a must always be attached

The bottom right side of page under **, you must write in any comments

RECONCILIATION REPORT **The Claremont of Lee Co** **02:21 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-6,635	equal to	-6,635	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	109,280	equal to	109,280	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	40,304	equal to	40,304	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	36,810	equal to	36,810	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	71,700	equal to	71,700	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	31,470	equal to	31,470	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	54,689	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	63,563	equal to	63,563	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	30,446	equal to	30,446	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	645,879	equal to	645,879	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,469,475	equal to	1,469,475	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	731,864	equal to	731,864	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	224,289	equal to	224,289	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	76,548	equal to	76,548	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	53,107	equal to	53,107	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,050,566	equal to	1,050,566	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	29,520	< or = to	29,520	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	54,689	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	82,448	equal to	82,448	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	13,440	equal to	13,440	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	156,965	equal to	156,965	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	27,691	equal to	27,691	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	105,808	equal to	105,808	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	40,330	equal to	40,330	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	55,726	equal to	55,726	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	129,245	equal to	129,245	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,774,695	equal to	1,774,695	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1

Dietary Consultant	7,083	< or = to	7,083	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	1,750	< or = to	1,750	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	135,411	< or = to	135,411	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,698	< or = to	7,175	-5,477	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,766	< or = to	1,766	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	55,726	equal to	55,726	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	79,842	equal to	79,842	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	340,396	equal to	340,396	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	11,878	equal to	11,878	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	3,893	equal to	3,893	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	53,107	equal to	53,107	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	29,520	equal to	29,520	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,167	equal to	1,186	-19	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	33,214	equal to	33,214	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,778,571	equal to	1,778,571	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	41,250	equal to	41,250	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	100,000	equal to	100,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,374,967	equal to	1,374,967	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	118,442	equal to	118,442	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	44,664	equal to	44,664	0	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-478,294	equal to	-478,294	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-14,940	equal to	-14,940	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,241,354	equal to	1,241,354	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1